DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155330	A. BUILDING _____ B. WING _____	C 01/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SALEM, THE	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00082922. Complaint IN00082922 - Substantiated, No deficiencies related to the allegation(s) are cited. Survey dates: January 10, 11, 12, 13, 14, 2011 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Survey Team: Donna Groan, RN, TC Avona Connell, RN Gloria Reisert, MSW Census bed type: SNF/NF: 91 Total: 91 Census payor type: Medicare: 10 Medicaid: 63 Other: 18 Total: 91 Sample: 19 Supplemental sample: 04 These deficiencies also reflect State findings in accordance with 410 IAC 16.2. Quality review completed 1/20/11 by Jennie Bartelt, RN.	F 000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitutes an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164	**F164 Personal Privacy/Confidentiality of Records**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Angela M. Owens | CEO/Administrator | 2/7/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure physician visits were conducted in private for 1 of 19 residents in a sample of 19 residents and 2 of 2 supplemental residents in a supplemental sample of 4 who were reviewed for privacy during medical treatment. (Residents #90, 100 and 101)	F 164	**A. It is the intent of this facility for all physicians visits and medical treatment to be conducted in private.** 1. **Corrective action taken:** a. Facility Administrator immediately in-serviced attending physician/Medical Director to ensure physician visits were conducted in private. DON in-serviced nurses that accuchecks will be conducted in private. 2. Residents Identified: There were no other residents affected. 3. **Measures taken:** All Licensed staff and Medical Director were in-serviced in regards to Personal privacy/Confidentiality of Records ensuring that physician visits are conducted in private and accuchecks are conducted in private. 4. **How Monitored:** CEO/DON will monitor the above corrective actions during daily rounds and will review in quarterly QA meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance. 2/13/2011.**	

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F 164	Continued From page 2 Findings include: 1. During a random observation on the secured unit on 1/11/2011 at 12:15 p.m., Physician #1 was observed to approach Resident #90 while she was seated at her table in the unit dining room to ask the resident how she was feeling with a request to open her mouth. Also seated in the dining room at this time were 26 residents at their tables also awaiting their lunch meal as well as 2 CNAs [certified nursing assistants] and 2 activity assistants helping set up resident drinks. The physician had asked the resident several times to open her mouth and to also stick out her tongue before she did. He then proceeded to place a finger in her mouth to look inside and at her tongue. Review of the clinical record for Resident #90 on 1/13/2011 at 12:40 p.m. indicated the resident had diagnoses which included, but were not limited to, depression and dementia Alzheimer type with disturbance of behavior. The 1/11/2011 physician's progress note indicated the resident was being examined due to oral thrush [white patches in mouth and on tongue] and that the resident was non-cooperative for the exam. During an interview with the Director of Nursing and the Administrator on 1/12/2011 at 2:55 p.m., they indicated Physician #1 had told them about his seeing a patient in the dining room during lunch and that of all people, he should have known better.	F 164		

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F 164	Continued From page 3 2. When interviewed during the group meeting on 1/12/2011 at 1:30 p.m. with five residents whom the Activity Director and Social Worker indicated at this time were alert, oriented and reliable, Resident #100 indicated the physician and the nurses who do daily accuchecks [check of blood sugar] often will do it wherever the resident happens to be but was okay with it. Resident #101 also indicated that this was just the way it was - the physician and staff just see you wherever you are. 3.1-3(p)(2)	F 164		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	**F280 Right to participate planning care - revise CP.** **It is the intent of the facility to revise/ Update a resident's care plan upon return from a hospitalization and to provide increased assistance with ADL's, ROM, mobility, and assistance with a new cast.** 1. **Action Taken:** In regards to resident #63 , The chart was reviewed immediately, including the care plan, and appropriate changes have been made. 2. **Others affected:** No other residents were affected.	

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the care plan was updated with revised interventions when a resident returned following hospitalization with decline in condition. The resident needed increased assistance with activities of daily living, range of motion, ambulation and mobility, and management of the cast which she frequently removed. The deficient practice affected 1 of 1 resident reviewed for change in condition in a sample of 19 residents. (Resident #63) Finding includes: Review of the clinical record for Resident #63 on 1/13/2011 at 9:13 a.m., indicated the resident was admitted on 6/3/2010 with a re-admission from the hospital on 12/23/10. Diagnoses included, but were not limited to, status post fractured (Left) hip and wrist. On 12/18/2010, Resident #63 was found on the floor of her bathroom. On 12/20/2010, due to increased swelling and pain in her left wrist and hip, the resident was sent to the hospital for treatment of her fractures and returned to the facility on 12/23/2010. The 1/4/2011 14 day Minimum Data Set [MDS] assessment indicated the resident had changes in her ambulation and mobility from being independent to extensive to total assist, a cast on her left wrist, increased assistance with activities of daily living , (i.e. bathing, grooming, dressing, and eating) and decreased range of motion. The care plans for the resident indicated the last	F 280	3. **Measures In Place:** DON/ADON will review chart/care plan of all re-admit/return resident, and discuss any changes in daily QA stand up meeting. Care plan will be updated/revised at that time. 4. **How Monitored:** CEO/DON will monitor the above corrective action and review in quarterly QA meeting. 5. **This plan of correction constitutes our creditable allegation of compliance with all regulatory requirements. Our date of compliance is February 13, 2011.**	

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F 280	Continued From page 5 care plan review was done on 10/28/2010. On 12/27/2010, a care plan was developed to address "Pain associated with the fractured left wrist and hip" and "Actual skin impairment related to the surgical site on the left hip". During an interview with the MDS coordinator and the Assistant Director of Nursing on 1/13/2011 at 11:20 a.m., they indicated that each department would update the care plans that were relevant to their department and that the ADON would update the nursing care plans whenever new orders were received. The MDS coordinator indicated the care plan team would meet and update the care plans each time new orders were received. Review of the nursing notes between 12/23/2010 and 1/13/2011 indicated the resident had removed her hard cast within the first few days of returning to the facility and had then continually removed her soft cast multiple times every day with the nurses having to go back and re-wrap it each time. When interviewed on 1/14/2011 at 9:25 a.m., the DoN indicated that the MDS coordinator told her that because the resident's wrist fracture did not trigger, she did not think it was an issue that needed to be addressed.	F 280		
F 282 SS=D	3.1-35(d)(2)(B) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	**F282 Services by Qualified Persons/ Per care Plan** **It is the intent of the facility to follow physician's orders and plan of care for annual chest x-ray for any resident with a positive tuberculosis test**	

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F 282	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow the physician's order and plan of care for an annual chest X-ray for 1 of 2 residents reviewed for a positive tuberculosis test reaction in a sample of 19 residents. (Resident #90) Finding includes: Review of the clinical record for Resident #90 on 1/13/2011 at 12:40 p.m., indicated the resident had diagnoses which included, but were not limited to, positive tuberculin reactor and chronic obstructive pulmonary disease. The January 2011 monthly physician orders signed by the physician on 1/11/2011 indicated the resident had an order dated 5/15/07 for "May have annual chest x-ray PPD is reactive." A care plan with an implementation date of 2/3/2009 and review date of 11/18/2010 indicated: "Problem: Allergy: positive PPD reactor" with approaches that included, but were not limited to, "...Annual chest x-ray." The lab section of the clinical record failed to indicate a chest x-ray having been performed since 11/14/08. When interviewed on 1/13/2011 at 2:37 p.m., the Director of Nursing indicated that after review of the clinical record, no chest x-ray had been performed since 11/14/08. The DoN also indicated that although the resident did have a current physician's order for an annual chest x-ray	F 282	1. **Action Taken:** In regards to pt # 90 chest x-ray was done on 1/18/11. No negative outcome was identified. 2. **Residents Identified:** 100% audit of all residents receiving Annual chest X-ray: #12, #26, #70: These residents have had chest x-ray with no negative outcome. 3. **Measures Taken:** All nurses were re-in serviced that all residents who are a positive PPD reactor will get a chest x-ray immediately. Then arrangements with Mobil X or other Vendor will be made to schedule for each year in November. 4. **How Monitored:** DON/ADON will ensure that arrangements are made with Mobil X or other vendor to automatically schedule x-rays for PPD reactors each year in November. The CEO/DON will review these audits in the daily QA stand-up meeting; monthly QA Meeting; and with Medical Director at the Quarterly Meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 13, 2011.**	

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F 282	Continued From page 7 since she was a positive PPD reactor and her care plan also indicated a chest x-ray would be done, no x-ray was necessary as the physician documented in his progress note the resident's lungs were CTA [clear to ausculation] and her monthly orders said she was free of TB in an infectious stage. 3.1-35(g)(2)	F 282		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure chemicals were secure for 2 of 2 observations on the secured unit. This had the potential to affect 30 residents who resided on the secured unit. Findings include: 1. During the initial tour of the secured unit on 1/10/2011 at 6:12 p.m., the nursing supply room was observed with the key in the lock and the door unlocked to the touch. The following items were observed inside the room: a. Conva Tec Skin Conditioner - (18) 8 ounce bottles. Review of the bottle label and/or MSDS	F 323	**F323 Free of Accident Hazards/Supervision/ Devices** **It is the intent of the facility that all hazardous Chemicals will be secured.** 1. **Action Taken:** All Chemical/Hazardous Materials were removed from the Nursing supply room in the Secured Unit and secured in the Facility Supply room. 2. **Residents Identified:** 100% audit was done of other areas to ensure that chemicals were secured, and all are secured. All residents have the potential to be affected.	

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F 323	Continued From page 8 [material safety data sheets] indicated: Keep out of reach of children. If swallowed, get medical help or contact Poison Control Center right away. b. Medi Pak anti-perspirant roll-on - (5) 1.5 ounce bottles. Review of the bottle label and/or MSDS [material safety data sheets] indicated: Keep out of reach of children. If swallowed, get medical help or contact Poison Control Center right away. c. Medline roll-on anti-perspirant/deodorant - (5) 1.5 ounce bottles. Review of the bottle label and/or MSDS [material safety data sheets] indicated: Keep out of reach of children. d. Hydrox Fresh Moments deodorant/anti-perspirant - (2) bottles. Review of the bottle label and/or MSDS [material safety data sheets] indicated: Keep out of reach of children. e. Top value denture cleanser tablets - (3) full boxes. Review of the box and/or MSDS [material safety data sheets] indicated: Can cause eye irritation. Expected to be slightly toxic by ingestion. If swallowed, do not induce vomiting....Call Poison Control Center. f. Polident Overnight Whitening denture cleanser - (1) box. Review of the box and/or MSDS [material safety data sheets] indicated: Keep out of reach of children and elderly needing care; do not place tablet in mouth; keep tablet solution out of mouth. Never attempt to induce vomiting; obtain medical attention. g. Medline razors - (4) boxes and (4) packages. h. Med Essentials Shaving Cream - (6) 1.5 ounce cans. Review of the bottle label and/or MSDS	F 323	3. **Measure Taken:** All staff In-serviced on potential accident/hazards/chemical incidents caused by leaving cabinets/door open keys in the door with harmful items exposed or available to the resident. Chemicals/Hazardous Materials removed immediately out of that Secured Dementia supply room. 4. **How Monitored:** QA/IDT will monitor for hazardous materials/chemicals items during daily QA rounds. DON will review daily audits. CEO/Designee will monitor during daily QA standup meeting, and review audits during monthly QA meeting and with Medical Director in quarterly QA Meeting. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance: Feb 13, 2011.**	

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F 323	Continued From page 9 [material safety data sheets] indicated: Keep this and all chemicals out of reach of children. i: Afta Shave after shave skin conditioning (original) - (2) 3 fluid ounce bottles. Review of the bottle label and/or MSDS [material safety data sheets] indicated: Keep out of reach of children, avoid contact with eyes. Seek medical attention if ingested. The Director of Nursing provided the MSDS on 1/13/2011 at 9:55 a.m. Four (4) residents were observed wheeling in the halls near the room, with 2 of them stopping to sit next to the door. When interviewed on 1/10/2011 at 6:20 p.m., CNA #1 [certified nursing assistant] indicated the nursing supply room was not supposed to be unlocked nor was the key supposed to be left in the lock as it was supposed to be kept on the upper hook. When interviewed on 1/10/2011 at 6:25 p.m., LPN #1 also indicated the door was not supposed to be left unlocked nor the key left in the lock. She indicated the residents on the unit were mostly confused to some degree - able to answer simple questions usually. 2. During an observation of the secured unit on 1/11/2011 at 10:30 a.m., the nursing supply room was observed to have the door open with the key in the lock. The same items identified on 1/10/2011 at 6:12 p.m. were noted to be in the room. Five (5) residents were observed to be rolling themselves around the unit in their wheelchairs, with 4 of them stopping to sit just	F 323		

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F 323	Continued From page 10 outside this open door. Staff were observed walking back and forth past the open door, as well as the Assistant Director of Nursing standing at the desk across from the open door. When interviewed at on 1/11/2011 at 10:32, CNA #2 indicated that the reason the door was open was because Activity Assistant #1 was feeding a resident across the hall from the door and needed it open. She indicated that the door was not supposed to be left open like that, and the key was supposed to be hung up. During the final exit meeting with the Administrator and all department heads at 11:00 a.m. on 1/14/2011, he indicated that the corporate office told him there was no policy on "Storage of Hazardous Materials" as the rule was to follow what the MSDS sheets instructed. 3.1-45(a)(1)	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	**F329 – Drug Regimen is Free of unnecessary drugs** **It is the intent of the facility for each resident's drug regimen to be free from unnecessary hypnotic usage without adequate monitoring and indications for use.**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SALEM, THE	200 CONNIE AVE SALEM, IN 47167

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F 329	Continued From page 11 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the residents' drug regimen was free from unnecessary hypnotic usage without adequate monitoring and indications for use for 1 of 5 residents reviewed for unnecessary drug usage in a sample of 19 residents. (Resident #48) Finding includes: Review of the clinical record for Resident #48 on 1/12/2011 at 10:22 a.m., indicated the resident was admitted on 9/110/2010 and had diagnoses which included, but were not limited to, toxic metabolic encephalopathy, depression and anxiety. The physician orders section of the clinical record indicated the resident had an order dated 10/27/2010 for Ambien [for sleep] 5 milligrams [mg] - 1 tablet every night at bedtime. The nursing notes dated 10/19/2010 indicated the resident had just returned from the hospital that day after a one day stay for a change in mental status and inability to verbalize.	F 329	1. **Action Taken:** All licensed nursing staff in-serviced related to, observation and documentation of signs and symptoms of issues , and using non-pharmaceutical interventions, prior to administering or requesting an order for medications. Suggestions for non – pharmaceutical interventions posted in front of Medication Records 2. **Others Identified:** No others identified at this time. 3. **Measures In Place:** DON/Designee will monitor/audit administration of Hypnotics for each resident with Hypnotics ordered qd to identify concerns related to not attempting three non-pharmaceutical interventions prior to using medication. These audits will continue until 100% compliance is obtained. All residents with a routine and/or prn Hypnotic will have a behavior program in place. The SSD/designee will perform audits qd for appropriate documentation prior to administration of a Hypnotic. These audits will continue until 100% compliance is obtained.	

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F 329	Continued From page 12 A nursing note dated 10/20/10 1P [1:00 p.m.] indicated "...Res [resident] care plan review [with] family R/T [related to] concerns res c/o [complaints] not sleeping @ [at] night et [and] agreeable that delusions are directly related to sleep pattern...will place call to [name of physician] for sleep aid." A nursing note dated 10/27/10 12:30 p.m. indicated "Rd [resident] c/o of insomnia over past several days. MD [physician] notified NO [new order] Ambien 5 mg PO [by mouth] q HS [every night]." Documentation was lacking by nursing and social services of having explored the resident's complaints of delusions and reasons for inability to sleep at night, as well as of non-pharmacological interventions tried before requesting a hypnotic. On 1/12/2011 at 2:40 p.m., the Administrator presented a copy of the facility's current policy on "Unnecessary Drugs". Review of this policy indicated: "C. Drugs Used for Sleep Induction: Drugs used for sleep induction should only be used if: (1) Evidence exists that other possible reasons for insomnia (e.g. depression, pain, noise, light, caffeine) have been ruled out...(3) Daily use of the drug is less than ten continuous days unless an attempt at a gradual dose reduction is unsuccessful...." During an interview with the Administrator on 1/13/2011 at 10:00 a.m., he indicated that after reviewing the resident's clinical record, he also failed to locate documentation by nursing and social services of the resident having difficulty sleeping on a daily basis and what interventions	F 329	4. **How Monitored:** These audits will be reviewed by DON/ADON and reviewed in Daily QA stand up meeting. Behavior audits will be reviewed in our quarterly QA meeting with Medical Director. **5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our completion date is February 13, 2011.**	

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F 329	Continued From page 13 were implemented before requesting a hypnotic. He also indicated no gradual dose reductions have been attempted since implementation of the medication on 10/27/2010. 3.1-48(a)(3) 3.1-48(a)(4)	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**F441 Infection Control** **It is the intent of the facility for all residents with a positive PPD to have an annual Chest X-Ray or annual screening per facility policy.** **1. Action Taken:** In regards to Resident # 90 chest x-ray was done on 1/18/11. No negative outcome was identified. **2. Residents Identified:** 100% audit of all residents who Are positive PPD Reactors. #12, #26, #70: These residents have had chest x-ray with no negative outcome. There were no other resident affected. **3. Measures Taken:** All nurses were re-in serviced that all residents who are a positive PPD reactor will get a chest x-ray immediately. Then arrangements with Mobil X or other Vendor will be made to schedule for each year in November.	

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F 441	Continued From page 14 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents who were positive tuberculin test reactors had an annual chest X-ray or screening per the facility policy. This deficient practice affected 1 of 2 residents reviewed for positive tuberculosis tests reactions in a sample of 19 residents. (Resident #90) Finding includes: Review of the clinical record for Resident #90 on 1/13/2011 at 12:40 p.m., indicated the resident had diagnoses which included, but were not limited to, positive tuberculin test reactor and chronic obstructive pulmonary disease. The January 2011 monthly physician orders signed by the physician on 1/11/2011 indicated the resident had an order dated 5/15/07 for "May have annual chest x-ray PPD is reactive." The lab section of the clinical record failed to locate a chest x-ray having been performed since 11/14/08. When interviewed on 1/13/2011 at 2:37 p.m., the DoN indicated that after review of the clinical record, no chest x-ray had been performed since 11/14/08. The DoN also indicated that although	F 441	4. **How Monitored:** DON/ADON will ensure that arrangements are made with Mobil X or other vendor to schedule x-rays for PPD reactors each year in November. The CEO/DON will review these audits in the daily QA stand-up meeting; monthly QA Meeting; and with Medical Director at the Quarterly Meeting. 5. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 13, 2011.**	

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F 441	Continued From page 15 the resident did have a current physician's order for an annual chest x-ray since she was a positive PPD reactor and her care plan also indicated an chest x-ray would be done, no x-ray was necessary as the physician documented in his progress note the resident's lungs were CTA [clear to ausculation] and her monthly orders said she was free of TB in an infectious stage. The DoN also at this time presented a copy of the facility's current policy on "Tuberculosis Surveillance". Review of this policy included, but was not limited to, "Policy: All employees, residents and volunteers will be screened for tuberculosis...Procedure for Resident:...9. Screen each tuberculin positive resident annually (do not Test). Complete the Resident and Employee Tuberculosis Screen Tool and file in the Medical Record. Document the presence or absence of symptoms of tuberculosis (i.e. weight loss, cough, fever)...." During an interview with the Director of Nursing on 1/12/2011 at 8:35 a.m., she indicated the physician did not do the annual health screens anymore as he/she will usually review the most recent chest x-ray and make a notation on it to indicate aware of results and free of symptoms. 3.1-18(i)	F 441		